

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

27546

1. PLACE OF DEATH

County Harrison Registration District No. 656
 Township Holland Primary Registration District No. 6281
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

No Name Scott

(a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female m 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-24-36

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 0 hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Holland

13. NAME C. L. Scott

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Harrison

15. MAIDEN NAME Carrie White

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Holland

17. INFORMANT C. L. Scott (ADDRESS) Holland mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Scottdale em DATE 7-26-36

19. UNDERTAKER Harrison mndt co (ADDRESS) Scottdale mo

20. FILED 8-8 134 Tom Engeler Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-25-1936

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 4 am.

The principal cause of death and related causes of importance were as follows:

Premature
157
 Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? If so, specify _____

(Signed) H. E. Cooper M. D.
 (Address) Scottdale mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHITE PEARL, WITH UNFADING INK—THIS IS A PERMANENT RECORD

